FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038307

Facility Name: Heritage Manor-Elgin

Address: 355 Raymond Street (Number) Elgin (City) 60120 (Zip Code)

County: Kane

Telephone Number: (847) 697-6636 **Fax #** ( )

HFS ID Number: 370909086011

Date of Initial License for Current Owners: 1989

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,002	4,577	2,993	29,572	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	22,002	4,577	2,993	29,572	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.19%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1989

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,993

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	219,693	14,668		234,361		234,361	4,149	238,510			1
2	Food Purchase		154,423		154,423		154,423		154,423			2
3	Housekeeping	99,244	26,698		125,942		125,942	4	125,946			3
4	Laundry	52,517	16,190		68,707		68,707		68,707			4
5	Heat and Other Utilities			123,392	123,392		123,392	1,309	124,701			5
6	Maintenance	84,567	39,000	38,113	161,680		161,680	10,974	172,654			6
7	Other (specify):*											7
8	TOTAL General Services	456,021	250,979	161,505	868,505		868,505	16,436	884,941			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,523,599	112,226	5,757	1,641,582		1,641,582		1,641,582			10
10a	Therapy		180,316	497,344	677,660	(472,449)	205,211	286,692	491,903			10a
11	Activities	62,546	3,523		66,069		66,069		66,069			11
12	Social Services	68,211	32	3,444	71,687		71,687		71,687			12
13	CNA Training		2,595		2,595		2,595	1,475	4,070			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,654,356	298,692	512,545	2,465,593	(472,449)	1,993,144	288,167	2,281,311			16
	C. General Administration											
17	Administrative	73,081			73,081		73,081	63,612	136,693			17
18	Directors Fees							4,722	4,722			18
19	Professional Services			290,822	290,822		290,822	(277,701)	13,121			19
20	Dues, Fees, Subscriptions & Promotions			86,648	86,648	(51,465)	35,183	(15,805)	19,378			20
21	Clerical & General Office Expenses	206,138	23,824	17,440	247,402		247,402	131,302	378,704			21
22	Employee Benefits & Payroll Taxes			382,433	382,433		382,433	34,175	416,608			22
23	Inservice Training & Education			3,942	3,942		3,942	(1,943)	1,999			23
24	Travel and Seminar			8,461	8,461		8,461	(6,462)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,377	62,377		62,377	1,676	64,053			26
27	Other (specify):*											27
28	TOTAL General Administration	279,219	23,824	852,123	1,155,166	(51,465)	1,103,701	(66,424)	1,037,277			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,389,596	573,495	1,526,173	4,489,264	(523,914)	3,965,350	238,179	4,203,529			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Elgin #0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,341	128,341		128,341	11,136	139,477			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,902	57,902		57,902	19,274	77,176			32
33	Real Estate Taxes			53,167	53,167		53,167		53,167			33
34	Rent-Facility & Grounds							5,751	5,751			34
35	Rent-Equipment & Vehicles			4,569	4,569		4,569	1,118	5,687			35
36	Other (specify):*											36
37	**TOTAL Ownership**			243,979	243,979		243,979	37,279	281,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					472,449	472,449		472,449			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					523,914	523,914		523,914			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,389,596	573,495	1,770,152	4,733,243		4,733,243	275,458	5,008,701			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(325)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(112)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,451)	20		17
18	Fines and Penalties				18
19	Entertainment	(15,214)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,634)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(18,347)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,050)	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,133)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	315,591		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 315,591		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 275,458		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Elgin

ID# 0038307

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(325)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,451)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,634)	19	22
23				23
24		0	27	24
25		(18,347)	20	25
26				26
27				27
28				28
29		(3,050)	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,807)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Manor-Elgin **#** 0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,149	0	0	0	0	0	0	0	0	4,149	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,309	0	0	0	0	0	0	0	0	1,309	5
6	Maintenance	0	0	10,974	0	0	0	0	0	0	0	0	10,974	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	16,436	0	0	0	0	0	0	0	0	16,436	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	286,692	0	0	0	0	0	0	0	0	0	286,692	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,475	0	0	0	0	0	0	0	0	1,475	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	286,692	1,475	0	0	0	0	0	0	0	0	288,167	16
	C. General Administration													
17	Administrative	0	0	63,612	0	0	0	0	0	0	0	0	63,612	17
18	Directors Fees	0	0	4,722	0	0	0	0	0	0	0	0	4,722	18
19	Professional Services	(1,634)	(289,188)	13,121	0	0	0	0	0	0	0	0	(277,701)	19
20	Fees, Subscriptions & Promotions	(19,798)	0	3,993	0	0	0	0	0	0	0	0	(15,805)	20
21	Clerical & General Office Expenses	0	0	131,302	0	0	0	0	0	0	0	0	131,302	21
22	Employee Benefits & Payroll Taxes	0	0	34,175	0	0	0	0	0	0	0	0	34,175	22
23	Inservice Training & Education	(3,050)	0	1,107	0	0	0	0	0	0	0	0	(1,943)	23
24	Travel and Seminar	(15,214)	0	8,752	0	0	0	0	0	0	0	0	(6,462)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,676	0	0	0	0	0	0	0	0	1,676	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(39,696)	(289,188)	262,460	0	0	0	0	0	0	0	0	(66,424)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,696)	(2,496)	280,371	0	0	0	0	0	0	0	0	238,179	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heritage Manor-Elgin **#** 0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	11,136	0	0	0	0	0	0	0	11,136	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112)	0	0	19,386	0	0	0	0	0	0	0	19,274	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,751	0	0	0	0	0	0	0	5,751	34
35	Rent-Equipment & Vehicles	(325)	0	0	1,443	0	0	0	0	0	0	0	1,118	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(437)	0	0	37,716	0	0	0	0	0	0	0	37,279	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,133)	(2,496)	280,371	37,716	0	0	0	0	0	0	0	275,458	45

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	289,188	Heritage Enterprises, Inc.	100.00%		(289,188)	4
5	V								5
6	V	10a	Adjustment for Related Organization	178,552	GreenTree Pharmacy	100.00%	465,244	286,692	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 467,740			$ 465,244	$ * (2,496)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 4,149	$ 4,149	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				4	4	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,309	1,309	19
20	V	6	Maintenance				10,974	10,974	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,475	1,475	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				63,612	63,612	29
30	V	18	Directors Fees				4,722	4,722	30
31	V	19	Professional Services				13,121	13,121	31
32	V	20	Fees, Subscription, Promotions				3,993	3,993	32
33	V	21	Clerical & General Office Expenses				131,302	131,302	33
34	V	22	Employee Benefits & Payroll Taxes				34,175	34,175	34
35	V	23	Inservice Training & Education				1,107	1,107	35
36	V	24	Travel and Seminar				8,752	8,752	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,676	1,676	38
39	Total			$			$ 280,371	$ * 280,371	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					11,136	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					19,386	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,751	20
21	V	35	Rent-Equipment & Vehicles					1,443	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 37,716	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	$ 14,353	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	16,097	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	9,585	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	12,491	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	6,163	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	6,908	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	2,737	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 68,334		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	94	$ 4,149	1
2	2	Food Purchase	Beds	2,612	25	7	0	94	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	94	4	3
4	4	Laundry	Beds	2,612	25	0	0	94	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	94	1,309	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	94	10,974	6
7	7	Other	Beds	2,612	25	0	0	94	0	7
8	9	Medical Director	Beds	2,612	25	0	0	94	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	94	0	9
10	11	Activities	Beds	2,612	25	0	0	94	0	10
11	12	Social Service	Beds	2,612	25	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	94	1,475	12
13	14	Program Transportation	Beds	2,612	25	0	0	94	0	13
14	15	Other	Beds	2,612	25	0	0	94	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	94	63,612	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	94	4,722	16
17	19	Professional Services	Beds	2,612	25	364,592	0	94	13,121	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	94	3,993	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	94	131,302	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	94	34,175	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	94	1,107	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	94	8,752	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	94	1,676	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 280,371	25

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	94	$	1
2	30	Depreciation	Beds	2,612	25	309,426		94	11,136	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			94		3
4	32	Interest	Beds	2,612	25	538,695		94	19,386	4
5	33	Real Estate Taxes	Beds	2,612	25			94		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		94	5,751	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		94	1,443	7
8	36	Other	Beds	2,612	25			94		8
9	38	Medically Nec Transportation	Beds	2,612	25			94		9
10	39	Ancillary Service Centers	Beds	2,612	25			94		10
11	40	Barber and Beauty Shops	Beds	2,612	25			94		11
12	41	Coffee and Gift Shops	Beds	2,612	25			94		12
13	42	Other	Beds	2,612	25			94		13
14								94		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 37,716	25

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	$	$ 670,839	01/15/06	variable	$ 37,829	1
2	LsSalle National Bank		xx	Mortgage							4,319	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							15,754	6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$	$ 670,839			$ 57,902	9
	B. Non-Facility Related*											
10	Interest Income										(112)	10
11												11
12	Central Office Allocation										19,386	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 19,274	14
15	TOTALS (line 9+line14)						$	$ 670,839			$ 77,176	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Elgin **#** 0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 50,128	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 50,388	2
3. Under or (over) accrual (line 2 minus line 1).	$ 260	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 52,907	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 53,167	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	38,576	8
2001	42,327	9
2002	42,058	10
2003	43,635	11
2004	49,307	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0038307

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-24-201-003	Heritage Manor-Elgin	$ 48,246.00	$ 48,246.00
2.	06-24-201-002		$ 1,218.00	$ 1,218.00
3.	06-24-201-004		$ 924.00	$ 924.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,388.00	$ 50,388.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,651 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 80,000	1
2					2
3	TOTALS			$ 80,000	3

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94				$ 720,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1989 Improvements			1989	180,739						9
10	1990 Improvements			1990	658,346						10
11	1990 Improvements			1990	4,320						11
12	1991 Improvements			1991	52,989						12
13	1992 Improvements			1992	6,777						13
14	1993 Improvements			1993	54,564						14
15	1994 Improvements			1994	81,347						15
16	1995 Improvements			1995	146,394						16
17	Remodel Resident Day Room/Nurses Station			1996	23,749						17
18	Interior Rehab			1997	751						18
19	Electric Water Heater			1997	3,965						19
20	Booster Heater			1997	1,622						20
21	Water Heater and Storage Tank			1998	6,485						21
22											22
23	Water Heater			1999	4,750						23
24	Code Alert System			1999	1,570						24
25	Resident Room Remodel--Material and Labor			1999	2,571						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							11,136	11,136		34
35	Book Depreciation					84,573		84,573		942,942	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	South Wing Remodel -- Labor / Materials	2000	$ 14,334	$		$	$	$	37
38	Door	2000	1,535						38
39	Dry Chemical Extinguisher	2000	1,746						39
40									40
41	Water Heater	2001	4,935						41
42	Valve thermometer	2001	4,520						42
43	A/C Unit	2001	3,319						43
44	Hallway Carpet and Tile Material and Labor	2001	28,843						44
45	Wallpaper	2001	2,390						45
46	Nurse Call System	2001	21,612						46
47									47
48	Hallway and Room Carpet and Tile Material	2002	74,533						48
49	Labor	2002	68,734						49
50	Professional Fees	2002	16,497						50
51	Kitchen Pipe	2002	1,830						51
52	Shower Repairs	2002	5,063						52
53	A/C Unit	2002	5,864						53
54	Bathroom Rehab	2002	750						54
55	Condensor	2002	1,600						55
56	Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57									57
58	Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59	Exterior Door	2003	320						59
60	Parking Lot Sealer	2003	4,469						60
61	Door Security	2003	2,160						61
62	Ductwork	2003	6,628						62
63	compressor	2003	1,195						63
64	Blower Unit	2003	1,784						64
65									65
66									66
67									67
68									68
69	Carpet								69
70	TOTAL (lines 4 thru 69)		$ 2,324,370	$ 84,573		$ 95,709	$ 11,136	$ 942,942	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,324,370	$ 84,573		$ 95,709	$ 11,136	$ 942,942	1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,330,146	$ 84,573		$ 95,709	$ 11,136	$ 942,942	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 592,145	$ 43,768	$ 43,768	$		$ 462,614	71
72	Current Year Purchases	15,675						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 607,820	$ 43,768	$ 43,768	$		$ 462,614	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,017,966	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,341	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,477	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,136	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,405,556	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,687 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		2,595		2,595
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,595	$	$ 2,595
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,595			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 228,426	$		$ 228,426	1
2	Licensed Speech and Language Development Therapist		hrs			43,535			43,535	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			218,629	1,313		219,942	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				465,695		465,695	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					6,754			6,754	13
14	TOTAL			$		$ 497,344	$ 467,008		$ 964,352	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Elgin **#** 0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,390	$	1
2	Cash-Patient Deposits	36,030		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	565,950		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,927		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	93,508		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 718,805	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,000		13
14	Buildings, at Historical Cost	2,330,146		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	607,819		16
17	Accumulated Depreciation (book methods)	(1,405,556)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	360		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,612,769	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,331,574	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 92,218	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,030		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,619		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,611		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,907		32
33	Accrued Interest Payable	3,721		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 402,106	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	670,839		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 670,839	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,072,945	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,258,629	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,331,574	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Elgin **#** 0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,254,279	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,254,279	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,350	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,350	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,258,629	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,532,668	1
2	Discounts and Allowances for all Levels	(1,297,105)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,235,563	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,171,412	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,171,412	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	181	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,638	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	327,575	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,112	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 330,506	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,737,593	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	868,505	31
32	Health Care	2,465,593	32
33	General Administration	1,155,166	33
	B. Capital Expense		
34	Ownership	243,979	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,733,243	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,350	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,350	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,080	$ 62,873	$ 30.23	1
2	Assistant Director of Nursing	1,976	2,080	56,720	27.27	2
3	Registered Nurses	16,084	17,626	487,738	27.67	3
4	Licensed Practical Nurses	5,889	6,490	145,957	22.49	4
5	CNAs & Orderlies	50,305	53,483	714,504	13.36	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,784	3,977	55,807	14.03	8
9	Activity Director					9
10	Activity Assistants	5,420	5,949	62,546	10.51	10
11	Social Service Workers	5,484	5,883	68,211	11.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,451	19,689	219,693	11.16	15
16	Dishwashers					16
17	Maintenance Workers	5,765	6,181	84,567	13.68	17
18	Housekeepers	10,864	11,813	99,244	8.40	18
19	Laundry	5,635	6,141	52,517	8.55	19
20	Administrator	1,900	2,080	73,081	35.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,510	12,032	206,138	17.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,083	155,504	$ 2,389,596 *	$ 15.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		6,000		36
37	Medical Records Consultant		633		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,910		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,444		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 12,987		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Hartman	admin		$ 73,081
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,081

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Admin	$ 289,188
		0
		0
		0
Legal-- Adjusted to zero		1,634
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 290,822

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,485
Unemployment Compensation Insurance	29,941
FICA Taxes	182,804
Employee Health Insurance	143,040
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	150
Employee Benefits -	10,013
Employee Benefits - central office	34,175
TOTAL (agree to Schedule V, line 22, col.8)	$ 416,608

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,848
Health Care Worker Background Check	
(Indicate # of checks performed)	300
Central Office Allocation	3,993
Promotional Advertising	3,965
Public Relations	14,382
Dues and Subscriptions	7,012
License and Fees	1,686
Less: Public Relations Expense	(14,382)
Non-allowable advertising	(1,451)
Yellow page advertising	(3,965)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,378

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,079
	0
Seminar Expense	5,382
	(15,214)
	8,752
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Elgin # 0038307 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **51,465**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-4,071,529	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	-74,415	
MEDIUM NURSING CARE		
HEAVY NURSING CARE	0	
SPECIAL CARE/HOME CARE		
NURSING SUPPLIES-PRIVATE	-345,156	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-327,575	
DRUGS-OTHER		
PT-PRIVATE	-1,171,412	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PT-MEDICARE ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	1,207,105	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-1,638	
ACTIVITY FUND INCOME	0	
ASSESSMENT TAX EXPENSE	0	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-40,568	
RESIDENT TRANSPORTATION	-1,112	
MISC INCOME	0	
GENERAL & ADMINIST WAGES	187,775	206,138
ADMINISTRATOR WAGES	73,081	73,081
VACATION & SICK - G&A	18,363	
EMPLOYEE BENEFITS	10,013	382,433
EMPLOYEE HEPETITIS VACCINE	158	
EMPLOYEE SCHOLORSHIP WAC	0	
EMPLOYEE SCHOLORSHIP COST	0	
DIRECTORS FEES		
OFFICE EXPENSES	23,824	23,824
TELEPHONE	17,440	17,440
TRAINING & EMPLOYEE DEVL	3,942	3,942
GENERAL TRAVEL	3,079	8,461
MEAL EXPENSE FOR TRAVEL	0	
EDUCATION & SEMINAR	5,382	
HELP WANTED ADVERTISING	5,848	86,648
PROMOTIONAL ADVERTISING	3,965	
PUBLIC RELATIONS	14,582	
LICENSES & FEES	55,141	
DUES & SUBSCRIPTIONS	7,012	
CONTRIBUTIONS	0	
PROFESSIONAL FEES	1,634	290,022
AUDIT & TAX FEES	6,000	6,000
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	633	
PHARMACIST FEES	2,910	
SOC SERV/ACT CONSULT	3,444	3,444
TV RENTAL	570	
INCOME TAXES		0
BACKGROUND CHECKS	300	
PAYROLL TAXES	205,479	
PAYROLL TAXES ADMINIST	7,266	
WORKMENS COMP	143,000	
LIABILITY INSURANCE	62,377	62,377
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	16,485	
CENTRAL OFFICE FEES	289,188	
BAD DEBTS	0	
LOST ITEMS-RESIDENTS	0	
MISCELLANEOUS	0	
REAL ESTATE TAXES	53,167	53,167
LEASED EQUIPMENT	3,088	4,569
MAINTENANCE SALARIES	81,104	84,567
MAINTENANCE SICK & VAC	3,463	
ELECTRIC	69,643	123,392
NATURAL GAS	8,504	
HEATING & DIESEL OIL		
WATER & SEWER	45,245	
TRASH COLLECTION	10,918	38,113
PROPERTY PLANT REPLACEMN	8,292	39,000
GENERAL REPAIR & MAINT	30,708	
MAINTENANCE CONTRACTS	27,194	
DIETARY WAGES	207,880	219,693
DIETARY SICK & VAC	11,813	
SALES TAX		
FOOD PURCHASES	154,423	154,423
SUPPLIES-DISHWASHING	2,750	14,668
DIETARY REPLACEMENT	3,294	
DIETARY SUPPLIES-PAPER	8,624	
MEAL CREDIT	0	
LAUNDRY WAGES	48,758	52,517
LAUNDRY SICK & VAC	3,759	
LAUNDRY REPLACEMENT	10,375	16,190
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	5,815	
HOUSEKEEPING WAGES	91,956	99,244
HOUSEKEEPING SICK & VAC	6,288	
HOUSEKEEPING SUPPLIES	14,464	26,698
HOUSEKEEPING SUPPLIES-PPR	12,234	
RN WAGES-MEDICARE		1,523,599
RN WAGES-NON MEDICARE	444,885	
RN BONUS	12,000	
ADON	54,720	
RN SICK & VACATION	42,853	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	141,240	
LPN WAGES OTHER		
LPN SICK & VACATION	4,717	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	650,324	
WARD CLERKS		
AIDE VACATION & SICK	64,180	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	2,595	2,595
NURSE AIDE TRAINING REIMB	-181	
REHAB WAGES	52,760	
REHAB SICK & VAC	3,047	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	102,171	112,226
NURSING SUPPLIES	4,410	
REPLACEMENT-NURSING	5,645	
NURSING-OTHER	2,214	5,757
DRUG PURCHASES	114,777	180,316
DRUG PURCHASES-OTHER	62,201	
LABORATORY SERVICES	6,754	497,344
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITIES WAGES	59,374	62,546
ACTIVITIES SICK & VAC	3,172	
ACTIVITIES SUPPLIES	3,523	3,523
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	219,629	
PT SUPPLIES	3,313	
SOCIAL SERVICE WAGES	66,198	68,211
SOCIAL SERVICE SICK & VAC	2,013	
SOCIAL SERVICE EXPENSES	32	32
OT FEE	228,426	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	43,535	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	0	0
BEAUTY SHOP SUPPLIES	0	0
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT		0
INTEREST EXPENSE	53,583	57,982
DEPRECIATION	128,341	128,341
LOAN FEE AMORTIZATION	4,319	
INTEREST INCOME	-112	
MISC NON-OPERATING INCOME	0	
INCOME TAXES	0	
	4,732,950	4,733,243
		293
	-4,550	
	(NET INCOME)	
	0	

						2,612	94	3,471,750	71,391,262		
	Name	Title	Function	Total Pay	usted by Mgmt F	otal # Beds	acility # Be	on-Nursing Hor	Nursing Home	This Facility	
###	Susie Jefferson	Director	Manageme	418,245	418,245			19,396	398,849	14,353	
###	Tom Jefferson	Secretary	Manageme	0	0			0	0	0	
###	Craig Hart	Chairman	Manageme	469,049	469,049			21,752	447,297	16,097	
###	Cheryl Lowney	Executive Vice Presic	Manageme	279,290	279,290			12,952	266,338	9,585	
###	Steve Wannemache	President	Manageme	363,969	363,969			16,879	347,090	12,491	
###	Connie Hoselton	Sr Vice President	Manageme	179,584	179,584			8,328	171,256	6,163	
###	Craig Ater	Sr Vice President	Manageme	201,279	201,279			9,334	191,945	6,908	
	Ben Hart			79,758	79,758			3,699	76,059	2,737	
13				1,991,174	1,991,174				1,898,834	68,334	